

**CAFETERIA PLAN
CHANGE IN STATUS/TERMINATION ELECTION FORM**

*Complete this form when a change in status has occurred which affects your Cafeteria Plan election.
This form must be submitted to your administrator within **30 days** of the event.*

Employer Name: _____

Employee Name: _____

Employee Address: _____

Employee Social Security Number: _____

If Terminating, Date of Last Deduction _____

Plan Year _____ through _____

As a Participant in the cafeteria plan, I am entitled to revoke my prior benefit election and enter into a new election in the event of certain changes in status.

I understand that the change in my benefit election must be necessitated by and consistent with the change in status and that the change must be acceptable under the Regulations issued by the Department of Treasury.

I certify that I have incurred the following change in status (please check next to applicable change):

Change in Marital Status

Change in legal marital status including marriage, death of the spouse, divorce, legal separation or annulment

Change in number of Tax Dependents

Change in the number of tax dependents, including birth, adoption, placement for adoption or death of a dependent.

Changes in Spouse or Dependent's Eligibility Under an Employer's Plan

Change in dependent status in satisfying or ceasing to satisfy the eligibility requirements of the plan, such as attainment of limiting age or student status or change in marital status

Judgment, decree or order including the imposition of a Qualified Medical Child Support Order

Gain or loss of Medicaid or Medicare entitlement

Entitlement to COBRA

Special requirements relating to the Family and Medical Leave Act (FMLA)

Change in Employment Status That Changes Eligibility Status

Change of employment status, such as termination or commencement of employment by the employee, spouse or dependent

Change in work schedule, such as a reduction or increase in hours of employment by the employee, spouse or dependent, including a switch between part-time and full-time, a strike or lockout, a change in worksite, or commencement or return from an unpaid leave of absence

Change in eligibility due to change in residency of the employee, spouse or dependent

Change in Cost or Coverage (applicable for health insurance and dependent care assistance account elections only and not for Unreimbursed Medical Spending Account)

Significant cost increase I your or your dependent's coverage

Significant curtailment of your or your dependent's coverage

Addition or elimination of benefit package option under your or your dependent's employer's plan

Change in coverage or open enrollment of spouse or dependent under other employer's plan provided that the employee, spouse or dependent elects coverage under the dependent's plan

Dependent care provider is replaced by another

Please change my election(s) as follows:

	Premium Elections		Unreimbursed Medical FSA		Dependent Care	
	FROM	TO	FROM	TO	FROM	TO
Annual Election Amount	\$	\$	\$	\$	\$	\$
Per Pay Period Election Amount	\$	\$	\$	\$	\$	\$
Date effective for Payroll change						

_____ Date _____
Employee's signature

Accepted and agreed to by _____
Administrator

By: _____ Date _____